STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	10/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEFFERSON COUNTY MEM HOSPITAL LTCU	408 DELAWARE STREET WINCHESTER, KS 66097

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint Investigation #69089.	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified	F 225		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 225	Continued From page 1 appropriate corrective action must be taken. This Requirement is not met as evidenced by: The facility had a census of 37 residents. The sample included 22 residents. Based upon observation, record review and interview the facility failed to investigate an injury of unknown source in a timely manner, failed to report a resident to resident altercation in a timely manner to the State survey and certification agency and failed to report a resident to resident altercation to the State survey and certification agency for 1 (#29) of 1 residents. Findings included: - Review of resident #29's significant change Minimum Data Set (MDS) 3.0 dated 9/7/13 identified the resident scored 1 (severely impaired cognition) on the Brief Interview for Mental Status, displayed physical behaviors and wandered on a daily basis during the 7 day look back period, had verbal behaviors 1 to 3 days of the 7 day look back and other behaviors not directed toward others 4 to 6 days of the 7 day look back period. A nurse's note dated 4/2/13 and timed 4:30 P.M. documented the resident sat at a dining room table where another usually sat, and dietary staff reported the resident (#29) threw ice water on a resident that sat at the table. A nurse's note dated 6/28/13 and timed 5:00 P.M. documented a resident hit resident #29 on the head with his/her cane. A nurse's note dated 8/10/13 and timed 12:00	F 225		

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F 225	Continued From page 2 P.M. documented staff observed the resident's lower bottom of the back with a bruise that measured 8 centimeters (cm) by 2 cm, a purple colored bruise on the resident's right ischium that measured 3 cm in diameter, and the resident complained of back pain. A Radiology Report dated 8/21/13 documented the resident had a history of posterior left rib pain, and had recent falls. The report included the impression was a nondisplaced inferior lateral left eighth rib fracture (broken rib bone). Review of the facility's investigation lacked evidence the facility thoroughly investigated the resident's left eighth rib fracture until the facility reported it to the State survey and certification agency on 9/17/13 (almost 1 month after the finding). On 10/16/13 at approximately 3:10 P.M. administrative nursing staff B stated the facility did not report the resident to resident altercation regarding the cane incident to the State survey and certification agency until 9/27/13. Administrative nursing staff B stated the facility did not report the resident to resident altercation regarding the resident throwing ice water on another resident. Administrative nursing staff B confirmed the facility did not report the resident's fractured rib until 9/17/13. On 10/16/13 at 9:00 A.M. the resident sat in a recliner in the lobby area of the facility. Review of the facility's Abuse, Neglect and Exploitation Policy and Procedure revised 8/2012 included all persons within the facility had the right to be free from abuse.	F 225		

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F 225	Continued From page 3 The facility failed to report allegations of abuse to the state agency, failed to report allegations of abuse in a timely manner to the state agency, and failed to thoroughly investigate an injury of unknown source as required.	F 225		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272		

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This Requirement is not met as evidenced by:
The facility had a census of 37 residents. The sample included 22 residents. Based upon record review, observation and interviews the facility failed to perform the Care Area Assessment when conducting a Significant Change Assessment for 1 (#13) of 22 residents.

Findings included:

- Resident #13 had diagnosis of late effect cerebrovascular disease (a group of brain dysfunctions related to disease of the blood vessels supplying the brain) listed on the October 2013 physicians order sheet signed and dated 10-2-13.

The revised care plan dated 9/17/13 for impaired mobility due to cerebrovascular accident with left sided weakness review, documented the intervention, the resident would appreciate staff helping him/her with his/her mouth care after breakfast each day.

The significant change Minimum Data Set (MDS) 3.0 dated 10-10-2013 documented the Brief Interview for Mental Status score of 13 which indicated intact cognition. The resident needed extensive assistance with one person physical assist for personal hygiene.

The clinical record lacked a Care Area Assessments for the 10/2/13 MDS.

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F 272	Continued From page 5 An observation on 10-16-13 at 10:13 A.M. revealed the resident wheeled himself/herself to his/her room from the breakfast table. At 10:30 A.M. staff entered the resident's room with a water pitcher and did not offer oral hygiene. Interview on 10-17-13 at 3:18 P.M. administrator nursing staff B stated staff need to reassess the resident to see what he/she wanted for oral care. The facility failed to provide a policy and procedure for comprehensive assessment regarding oral care. The facility failed to complete a comprehensive assessment for oral care for this dependent resident.	F 272		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who	F 278		

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willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.

Clinical disagreement does not constitute a material and false statement.

This Requirement is not met as evidenced by:
The facility had a census of 37 residents. The sample included 22 residents. Based upon observation, record review and interviews the facility failed to ensure the accuracy of 3 (#21, #20, #23) of 22 residents' Minimum Data Set assessment.

Findings included:

- Resident #21's significant change Minimum Data Set (MDS) 3.0 dated 7/23/13 revealed a Brief Interview for Mental Status score of 2 (severe cognitive impairment). The resident required extensive assistance of two plus (2+) persons for bed mobility, transfer, and toilet use, and required extensive assistance of one person for locomotion on/off the unit, dressing, personal hygiene, and bathing, and supervision with set up help only with eating. The resident was 64 inches tall and weighed 136 pounds (#); was on a physician weight loss regimen, had no weight gain, and received a mechanically altered diet.

The Nutritional Care Area Assessment dated 7/25/13 revealed the resident fed her/himself a regular blended diet with honey thick liquids. She/he ate well at meals and took fluids at and between meals.

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The care plan dated 1/10/13 for at risk for significant weight loss revealed the resident used a plate guard to help load food onto her/his silverware, received pureed with honey thick liquids as ordered, nursing staff would give the resident time to feed her/himself, nursing staff would weigh the resident weekly and notify the physician of any weight change 3# or more in one week, monitored and documented the percentage of food eaten, and he/she had left side drooling from her/his mouth and needed a clothing protector.

The Nursing Weight and Nutrition Note to Provider dated 9/2/13 at 5:45 P.M. revealed the resident had a weight loss of 5.9% in six months for March 2013, 5.71% in July 2013 at 3 months, and 0.3 percent (%) in August 2013;

The resident weights were: 5/1/13-137.9#, 6/6/13-140.8#, 7/1/13-136.3#, 8/12/13-133.2#, 9/8/13 - 134#, and 10/2/13 - 128.1#.

Observation on 10/16/13 at 7:30 A.M. revealed the resident received a pureed breakfast and ate 75% by her/his self.

Observation on 10/16/13 at 7:40 A.M. revealed direct care staff T provided Ensure Plus to the resident and she/he consumed 100%.

Interview on 10/17/13 at 11:15 A.M. with Administrative nursing staff E stated the resident was not on a weight loss regimen and the MDS was marked in error.

The facility failed to provide a policy and procedure for MDS completion.

The facility failed to complete an accurate

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assessment for this cognitively impaired resident with weight loss.

- The Significant Change Minimum Data Set 3.0 (MDS) dated 10/3/13 for resident #20 documented a Brief Interview for Mental Status score of 2 (less than 7 indicated severely impaired cognition). The resident required extensive assistance of two staff for all transfers.

The Care Area Assessment for Activities of Daily Living/Rehabilitation Potential did not trigger.

The care plan dated 10/10/13 noted the side rails at the head were up on both sides to enable self-transfers.

Observation of the resident on 10/16/13 at 1:30 P.M. the resident used one side rail to sit up in bed, and stood up without using the side rail or needing staff assistance.

Interview on 10/16/13 at 1:00 P.M. direct care staff Q stated this resident was able to get out of bed and up to the restroom without assistance from staff.

Interview on 10/16/13 at 5:05 P.M. direct care staff U stated the resident did not require any more assistance during the night than during the day.

Interview on 10/16/13 at 4:10 P.M. licensed nursing staff I stated this resident could get out of bed without staff assistance.

Interview on 10/17/13 at 11:05 A.M. administrative staff E stated the information on

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F 278	Continued From page 9 the MDS about the amount of assistance the resident required for transfers was incorrect. The facility failed to provide a policy for MDS accuracy. The facility failed to accurately assess the assistance this resident required for transfers. - The Annual Minimum Data Set 3.0 (MDS) dated 9/3/13 for resident #23 noted a Brief Interview for Mental Status score of 15 (13 to 15 indicated intact cognition), and it documented this resident had a wound infection. The care plan dated 9/10/13 lacked interventions related to wound care. Observation on 10/17/13 at 10:00 A.M. the resident rested in bed. Interview on 10/16/13 at 4:10 P.M. licensed nursing staff I stated this resident did not have a wound infection. Interview on 10/17/13 at 8:15 A.M. administrative staff E stated the information on the MDS about a wound infection was incorrect. The facility failed to provide a policy for MDS accuracy. The facility failed to accurately assess this resident's wound status.	F 278		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be	F 280		

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F 280	Continued From page 10 incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This Requirement is not met as evidenced by: The facility reported a census of 37 residents. The sample included 22 residents. Based on observation, record review, and interview the facility failed to individualize the care plans for 2 (#21 and #36) residents sampled for accidents, behaviors, pressure ulcers, and nutrition. Findings included: - The significant change Minimum Data Set 3.0 dated 7/23/13 for resident #21 revealed a Brief Interview for Mental Status score of 2 (severe cognitive impairment). The resident required extensive assistance of two plus (2+) persons for bed mobility, transfer, and toilet use, and required extensive assistance of one person for locomotion on/off the unit, dressing, personal hygiene, and bathing. The resident was not steady and stabilized with staff assistance with	F 280		

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moving from a seated to standing position, walking, turning around while walking, moving on/off the toilet, and surface to surface transfers. She/he had range of motion limitations to the upper/lower extremities on one side, and used a walker and wheelchair (w/c) for mobility. The resident was frequently incontinent of urine and always continent of bowel. She/he had two or more non-injury falls since admission/reentry/prior assessment.

The Care Area Assessment (CAA) dated 7/25/13 for falls revealed the resident had all of her/his toes and part of her/his right foot removed as a result of a job accident in the 1960's. Her/his right foot, left hemiparesis (muscular weakness of one half of the body), and aphasia (condition in which language function is disordered or absent) placed the resident at risk for falls. The resident wore a special orthotic shoe on her/his right foot and an athletic shoe on the left foot. A pummel cushion was used to discourage standing without assistance, and as a reminder to wait for assistance for transfer. The resident had a floor mat beside the left side of the bed and quarter rails in an up position on either side of the bed to assist with repositioning in bed.

The updated care plan dated 8/30/13 for at risk for falls revealed the resident required assistance of 2 to 1 with a gait belt for transfers and toileting, required a gait belt with all ambulation, nursing staff would monitor for changes in the resident's condition which warranted increased supervision/assistance and would notify the physician of significant concerns, the resident used a w/c for long distance mobility, side rails in up position for bed mobility while in bed, nursing staff would remind the resident to ask and wait for assist with transfers and ambulation, from upon

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F 280	Continued From page 12 rising and before/after meals, and provided perineal care when incontinent. Record review on 10/16/13 at 4:00 P.M. of handwritten fall events and interventions provided by administrative nursing staff A revealed: The NN dated 5/25/13 at 11:30 A.M. revealed staff found the resident on the bathroom floor. The Care Plan Update of Falls revealed nursing staff increased nursing monitoring of the resident. The NN dated 7/9/13 at 3:30 P.M. revealed staff found the resident on the floor in her/his room. The handwritten record lacked a fall intervention. The Care Plan Update of Falls dated 7/9/13 lacked a fall intervention. The NN dated 7/29/13 at 6:10 A.M. revealed staff found the resident on the floor in the bathroom. The Care Plan Update of Falls revealed nursing staff increased monitoring frequency. Record review on 10/16/13 at 4:00 P.M. of handwritten fall events and interventions provided by administrative nursing staff A revealed the resident had a non-injury fall on 9/19/13 and staff encouraged the resident to wear appropriate footwear when ambulating. The NN dated 9/29/13 at 10:25 P.M. revealed staff found the resident sitting on the floor in front of her/his w/c. The updated care plan dated 9/30/13 revealed staff would move the personal body alarm out of the resident's reach and apply side rails for mobility. Observation on 10/16/13 at 7:34 A.M. revealed the resident sat in a w/c, self-propelled in the hallway, and wore a PBA.	F 280		

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F 280	Continued From page 13 Observation on 10/16/13 at 9:44 A.M. revealed the resident laid in bed sleeping, wore a PBA, the side rails were in up position with the bed in low position. The revised fall care plan dated 9/30/13 lacked documentation to place the bed in a low position. Interview on 10/17/13 at 10:53 A.M. with direct care staff Q stated nursing staff educated the resident regarding the consequences of transferring her/himself without assistance, required visual monitoring, sat in a recliner chair in the common area, wore PBA while in bed/wheelchair, the bed placed in low position, and the resident could not be left alone in the bathroom during toileting. Interview on 10/17/13 at 11:23 A.M. with licensed nursing staff H stated the resident wore a PBA while in bed/wheelchair. The resident's family did not want a bed alarm used. The resident was not steady enough to ambulate by her/himself due to not having one whole foot. Nursing staff updated the care plans. Interview on 10/17/13 at 2:37 P.M. with administrative nursing staff D stated nursing staff updated the care plans. The facility failed to provide a policy and procedure for revision of care plans. The facility failed to revise the fall care plan for this cognitively impaired resident with a history of numerous falls. - The significant change Minimum Data Set 3.0	F 280		

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dated 8/26/13 for resident #36 revealed the resident had a Brief Interview for Mental Status score of 0 (severe cognitive impairment). Behaviors directed to others occurred one to 3 days which put others at risk for injury, and rejection of care behavior occurred daily during the 7 day look back period. The resident required extensive assistance of two plus persons (2+) for bed mobility, walking in the room/corridor, dressing, toilet use, and bathing, required total dependence of 2+ persons for transfers and locomotion off the unit, required extensive assistance of one person for locomotion on the unit, and supervision of one person for eating. The resident had a swallowing disorder of holding food in her/his mouth/cheeks, and cough/choked with meals/medications. The resident weighed 135 pounds (#). The resident was on a physician prescribed weight loss regimen, had no weight gain, and received a mechanically altered diet. The resident had a stage 2 pressure ulcer dated 7/11/13. The pressure ulcer treatment included pressure reducing device on the bed/chair, turning/repositioning, nutrition/hydration, pressure ulcer care, application of dressings, and application of ointments/medications.

The Care Area Assessment (CAA) for behaviors dated 8/26/13 revealed the resident hit, kicked, spit, and scratched during activities of daily living (ADL) cares, and often resisted staff helping with transfers.

The CAA for nutrition dated 8/26/13 revealed the resident began pocketing food, had difficulty or delayed swallowing and chewed food over long periods of times which the resident removed or spit out the food she/he had chewed. Speech therapy worked with the resident and the resident improved. The resident had difficulty feeding self

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because of poor sitting, and held her/his head back instead of sitting forward. The resident enjoyed chocolate milk.

The CAA for pressure ulcer dated 8/26/13 revealed the resident had a healing stage 2 area on the left inner knee, which was a fading 3 millimeter (mm) pink spot, and closed. The resident did not leave the cushion (a pillow or padded ankle riser) between the knees to decrease pressure. Nursing staff repositioned the resident regularly.

The care plan updated 9/17/13 for the resident touched female staff inappropriately, and could be mean to staff, revealed the resident was ornery and liked to joke. The resident reached out inappropriately to touch body areas of female staff. It worked best for the resident if she/he was handled with a joke to get the resident to remove her/his hand from nursing staff. Nursing staff would provide back massages during the period of possible anxiety when she/he would allow, to significantly decrease anxiety or perception of tension. Nursing staff would monitor indications of depression and would call the physician with concerns. Nursing staff would observe for changes in the resident's mental status and document significant behavior or change in the level of alertness and report any significant concerns to the physician, and provide consistent caregivers as much as possible on all shifts.

The Nursing Notes (NN) dated 7/6/13 at 5:10 A.M. revealed the resident was up most of the shift and required one to one (1:1), was very restless, hitting, and spitting at staff during cares. Nursing staff continued to toilet the resident every 2 hours related to incontinence, and used a standing-lift as the resident hit at staff.

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The care plan lacked documentation of resident behaviors.

The care plan updated 9/17/13 for actual significant weight loss revealed nursing staff would encourage/help the resident as needed to take all or most of her/his liquids, and the resident received a blended diet as the resident pocketed her/his food and became fatigued chewing very lengthy on every bite. Occupational therapy would evaluate and treat the resident for poor sitting balance. Nursing staff would invite and help the resident to all meals in the dining room, he/she enjoyed the cherry pie provided by family members, and used weighted silverware with meals.

The Physician Communication Order form dated 8/12/13 revealed the resident lost 7.8 # in the past 30 days and ordered Boost/Ensure one can daily for weight loss.

The care plan lacked documentation the resident received Boost/Ensure for weight loss.

The care plan dated 7/11/13 for stage 2 pressure area on the inner lateral left knee from a shear type wound from the resident's knees rubbing together when in bed, revealed nursing staff cleaned and applied triple antibiotic ointment and covered the area with antimicrobial adhesive bandage, kept a pillow between the resident's knees when in bed, documented if the resident refused to keep the pillow between her/his legs, monitored the size and documented the wound character weekly, and notified the physician if the wound was not improving or if signs and symptoms of infection was noted, staff to keep the wound clean and dry, wash the resident after

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each incontinent episode, and change to clean briefs/clothes as needed when soiled, staff would assess the resident's skin each bath day, and each shift with cares, reported any signs/symptoms of skin problems to the charge nurse, maintained a pressure relief mattress to the resident's bed, and a pressure relief pummel cushion (cushion with elevated part in the middle to prevent a resident from rising from the chair) in her/his wheel chair, checked and repositioned every 2 hours, nursing staff would shorten the check times if there was evidence of skin redness, and the resident used bilateral foot pedals.

The care plan lacked documentation the pressure wound healed 8/19/13.

The Behavioral Monitoring Forms for July 2013, August 2013, September 2013, and October 1 to 15, 2013 listed behaviors of hitting, kicking, pinching, scratching, spitting, restlessness, and increased agitation and he/she received Depakote (anti-seizure/mood enhancer) 250 milligrams (mg) at night.

The August 2013 Treatment Administration Record revealed the left inner knee pressure ulcer had healed on 8/19/13.

Observation on 10/16/13 at 8:30 A.M. revealed the resident ate 100 percent (%) of her/his breakfast and received a second glass of chocolate milk.

Observation on 10/16/13 at 1:00 P.M. revealed direct care staff Q and R assisted the resident to a standing position for incontinence care, there were no reddened or open areas noted to the buttocks or left/right inner knees.

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F 280	Continued From page 18 Observation on 10/16/13 at 3:15 P.M. revealed a chocolate shake/supplement snack was available for the resident but he/she was out to a physician's appointment Interview on 10/17/13 at 10:53 A.M. with direct care staff Q stated the resident did not show behaviors on her/his shift. She/he was not aware of any open areas on the resident. Pressure ulcer interventions consisted of repositioning the resident every 2 hours and more if needed, donuts (inner leg cushions) between the resident's knees so the skin did not touch. The resident received chocolate Ensure at meals. Interview on 10/17/13 at 1:30 P.M. with licensed care staff H stated the resident did not demonstrate any behaviors. The resident received Boost/Ensure daily and consumed 100% as she/he liked chocolate milk. Nursing staff updated the care plan with new orders or with a change in the resident. Interview on 10/17/13 at 2:37 P.M. with administrative nursing staff D stated the MDS Coordinator developed the care plans and nursing staff updated the care plan. The facility failed to provide a policy and procedure for revision of care plans. The facility failed to revise the care plan for behaviors, nutrition, and healed pressure ulcers for this cognitively impaired resident.	F 280		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident	F 314		

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who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

This Requirement is not met as evidenced by:
The facility had a census of 37 residents. The sample included 22 residents. Based upon observation, record review and interviews the facility failed to promote the prevention of pressure ulcers for 1 of 3 sampled residents (#19).

Findings included:

- Review of resident's #19's Significant Change Minimum Data Set (MDS) 3.0 dated 9/16/13 identified the resident scored 0 (severely impaired cognition) on the Brief Interview for Mental Status, and had behaviors 4 to 6 days of the 7 day look back period. The MDS identified the resident required extensive staff assistance with bed mobility, locomotion on/off unit, was totally dependent upon staff for transfers, walking in the room, dressing, eating, toilet use, and personal hygiene. The MDS coded the resident was frequently incontinent of urine, weighed 166 pounds, had not experienced a weight loss, and was at risk for pressure ulcer development. The MDS recorded the resident had (1) Stage I pressure ulcer, a pressure relieving device for his/her chair and on his/her bed, was on a turning/repositioning program, and received pressure ulcer care.

The resident's clinical record did not support the

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facility completed the Care Area Assessments as required after completing the significant change assessment (a comprehensive assessment).

The resident's care plan with a review date of 9/17/13 addressed the resident was at risk for skin breakdown due to being incontinent and the resident moved around a lot. Staff monitored the resident's bony areas and pressure points during dressing, bathing and toileting, the resident had a pressure relieving device in his/her chair and on his/her bed. The above interventions were in place since 5/21/11. The care plan included the resident had a Stage I pressure ulcer on his/her left hip, and staff repositioned the resident off his/her left hip as much as possible. A hand written entry dated 8/30/13 included the resident received Ensure pudding for lunch and dinner, and super cereal at breakfast. An undated entry documented heel protectors on heels when in bed. Review of the resident's care plan on 10/15/13 at approximately 2:30 P.M. did not address the resident's turning/repositioning program or the heel protectors.

A wound report dated 8/19/13 documented the Stage I pressure ulcer on the resident's left hip measured 4 centimeters (cm) by 3 cm and on 9/15/13 it measured 1 1/2 cm by 1 1/2 cm.

According to the resident' September 2013 Treatment Administration Record the pressure ulcer on the resident's left hip was healed as of 9/23/13.

A nurse's note dated 8/1/13 and timed 4:50 A.M. included the resident had 2 small abrasions; 1 on his/her right hip that measured 1.2 centimeters (cm) by 3 cm and (1) on his/her right inner thigh

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that measured 6 cm by .1 cm, and staff applied barrier cream.

A nurse's note dated 8/19/13 and not timed documented the resident had an area of redness on his/her left hip that measured 4 cm by 3 cm and staff encouraged this resident with severely impaired cognition to lie on his/her right side or back.

A nurse's note dated 10/1/13 and timed 4:30 A.M. documented the resident's buttocks was red and staff applied barrier cream. The note included both of the resident's heels were mushy and staff applied heel protectors.

A nurse's note dated 10/15/13 and timed 2:00 P.M. included the resident's right hip had a water filled blister that measured 2 cm by 2 cm,

A nurse's note dated 10/16/13 and not timed documented the resident's left hip had a red blanchable area that was 4 cm in diameter.

A nurse's note dated 10/17/13 and timed 4:00 A.M. documented the resident continued with the blister on his/her right hip, and staff observed the resident's left hip was red after the resident laid on his/her left hip for 1 to 1 1/2 hours. Staff repositioned the resident every 1 1/2 hours throughout the night, and the redness went away after staff repositioned the resident.

The resident's clinical record did not support the facility had performed a tissue tolerance testing (ability of the skin to withstand the effects of unrelieved pressure) in order to individualize the resident's repositioning schedules when in bed and in the chair.

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A registered dietician's note dated 8/28/13 documented the resident weighed 163 pounds, and the resident had a gradual weight loss. The note included the resident's weight decreased 4.5 percent (%) in 1 month, 3% in 3 months, 7.8% in 6 months, and the RD recommended 2 cal (nutritional supplement to increase the resident's protein and calorie intake) 60 cubic centimeters twice a day to try and stabilize the resident's weight.

The resident's laboratory report dated 10/9/13 recorded the resident's low serum albumin (indicator of protein storage) level at 2.6 grams/dl (g/dl), normal reference level at 3.5-5.2 g/dl. The report recorded the resident's low total protein as 5.3 g/dl, normal reference range of 6.6-8.7 g/dl.

On 10/15/13 at 1:45 P.M. the resident laid in bed on his/her right side. Observation revealed the resident had a pressure relieving device on his/her bed and in his/her recliner.

On 10/15/13 at 3:11 P.M. the resident laid in bed on his/her right side. Observation revealed the resident had a pillow between his/her legs, heel protectors bilaterally and the resident's heels/feet were not floated. Observation revealed the resident had a pressure relieving device on his/her bed, in his/her recliner but the resident's wheelchair did not have a pressure relieving device.

On 10/16/13 at 7:05 A.M. the resident sat in his/her room in his/her wheelchair. Observation revealed the resident's wheelchair was without a pressure relieving device.

On 10/6/13 at 7:30 A.M. direct care staff wheeled the resident to a dining room table. Observation

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revealed the resident's wheelchair did not have a pressure relieving device.

Observation revealed the resident continued to sit at a dining room table in his/her wheelchair without a pressure relieving device at 7:45 A.M., 7:53 A.M., 7:57 A.M., 8:03 A.M., 8:08 A.M. 8:20 A.M. 8:25 A.M. 8:35 A.M., 8:40 A.M., 8:55 A.M.

On 10/16/13 at 8:55 A.M. staff wheeled the resident to the lobby area of the facility.

On 10/16/13 at 9:05 A.M. observation revealed the resident sat in his/her wheelchair in his/her room, and no pressure relieving device in his/her wheelchair. The resident sat in his/her wheelchair for 2 hours without a pressure relieving device.

On 10/16/13 at 9:15 A.M. the resident sat in the recliner in his/her room. Observation revealed a pressure relieving device in the resident's recliner. Further observation revealed the resident had heel protectors on but the resident's heels were not floated.

On 10/16/13 observation revealed the resident continued to sit in the recliner at 9:30 A.M., 9:45 A.M., 10:00 A.M., 10:15 A.M., 10:30 A.M., 10:45 A.M., 11:00 A.M., 11:15 A.M., 11:30 A.M., 11:45 A.M., 12:04 P.M., 12:10 P.M., 12:20 P.M., and 12:30 P.M. (duration of 3 hours and 15 minutes).

On 10/16/13 at 12:30 P.M. the resident sat in the recliner in his/her room. Direct care staff P and R entered the resident's room. Staff removed the resident's blanket and observation revealed the resident had a pillow under his/her legs but the pillow was not positioned to float the resident's heels. Direct care staff P and R transferred the

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resident from the recliner to the resident's wheelchair. Observation revealed the resident's wheelchair without a pressure relieving device and staff did not check the resident for incontinence.

On 10/16/13 at 1:30 P.M. direct care staff P and R transferred the resident from the wheelchair to the resident's bed. Observation revealed the resident was incontinent of urine. Further observation revealed a red area on the resident's right thigh (where the blister was) that measured approximately 2 cm by .5 cm. Observation also revealed the resident's buttock red. Staff performed incontinent care, placed the heel protectors on the resident, placed a pillow between the resident's legs, and positioned the resident on his/her right side. Observation revealed staff did not float the resident's heels. During interview with direct care staff R at that time he/she stated staff repositioned the resident at least every 2 hours.

On 10/16/13 at 2:50 P.M. licensed nurse I entered the resident's room to perform a skin assessment. Observation revealed the resident had a red area on his/her right hip (where the blister was). During interview with licensed nurse I at that time, he/she stated the tape on the resident's brief caused the blister. Observation also revealed the resident's left hip red and the red area measured 4 centimeters in diameter (measurement provided by licensed nurse I). Observation revealed the resident's heels intact. Direct care staff P entered the resident's room and stated staff turned the resident less than a 1-1/2 hours ago and questioned why the resident's left hip was red.

On 10/17/13 at 9:20 A.M. the resident sat in

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F 314	Continued From page 25 his/her wheelchair at a dining room table. Observation revealed the resident's wheelchair was without a pressure relieving device. On 10/17/13 at 9:29 A.M. licensed nurse H stated he/she did not know if the resident should have a pressure relieving device in his/her wheelchair. Licensed nurse H read the resident's care plan and stated he/she was not sure if the resident should have a pressure relieving device in both the recliner and the wheelchair or just in the recliner. On 10/17/13 at 3:00 P.M. licensed nurse H stated the resident should have a pressure relieving device in the recliner and the wheelchair. Licensed nurse H stated staff repositioned the resident every 2 hours when in bed and in the chair/recliner. Licensed nurse H stated the resident had a Stage 1 pressure ulcer that healed on 9/23/13. The facility did not provide a pressure ulcer policy and procedure. The facility failed to assess the resident to develop an individualize turning/repositioning program, failed to float the resident's heels, failed to place a pressure relieving device in the resident's wheelchair, and failed to reposition this resident with a history of pressure ulcers timely.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident	F 315		

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who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

This Requirement is not met as evidenced by:
The facility reported a census of 37 residents. The sample included 22 residents of which 3 were reviewed for incontinence. Based on observation, record review, and interview, the facility failed to establish a voiding pattern for 2 (#33 and #21) residents in the sample.

Findings included:

- The significant change Minimum Data Set 3.0 (MDS) dated 7/23/13 for resident #21 revealed a Brief Interview for Mental Status score of 2 (severe cognitive impairment). The resident required extensive assistance of two plus persons (2+) for bed mobility, transfers, and toilet use, and extensive assist of one person for dressing, personal hygiene, and bathing. The resident had range of motion limitation to her/his upper/lower extremity on one side and used a walker and w/c for mobility. The resident was frequently incontinent of urine and always continent of bowel, and had two or more non-injury falls since admission/reentry/ prior assessment.

The Care Area Assessment (CAA) dated 7/25/13 for falls revealed the resident had all her/his toes and part of her/his right foot removed as a result of a job accident in the 1960's. Her/his right foot, left hemiparesis (muscular weakness of one half of the body), and aphasia (condition in which language function is disordered or absent) placed the resident at risk for falls. The resident wore a special orthotic shoe on her/his right foot and an

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athletic shoe on the left foot. A pummel cushion was used to discourage standing without assistance, and as a reminder to wait for assistance for transfer. The resident had a floor mat beside the left side of the bed, and quarter rails in an up position on either side of the bed to assist with repositioning in bed.

The updated care plan dated 8/30/13 for risk for falls revealed the resident required assistance of 2 to (:) 1 with a gait belt for transfers and toileting, required the use of a gait belt with all ambulation, nursing staff would monitor for changes in the resident's condition which warranted increased supervision/assistance, and would notify the physician of significant concerns, the resident used a w/c for long distance mobility, side rails were in the up position for bed mobility while in bed, nursing staff would remind the resident to ask and wait for assist with transfers and ambulation, toilet upon rising and before/after meals, and provided pericare when incontinent.

Record review on 10/16/13 at 4:00 P.M. of handwritten fall events and interventions provided by administrative nursing staff A revealed:

The Nursing Notes (NN) dated 5/10/13 at 8:00 A.M. revealed at 7:50 A.M. the resident tried to transfer self to the toilet in her/his room without help, lost her/his balance and fell to the floor.

The NN dated 5/12/13 at 6:50 P.M. revealed the resident was assisted to the toilet by nursing staff after the evening meal and after checking on the resident, left the resident on the toilet and when nursing staff returned, found the resident on the floor.

The NN dated 5/15/13 at 4:30 P.M. revealed the

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resident was found on the floor in the doorway of her/his bathroom.

The NN dated 5/25/13 at 11:30 A.M. revealed the resident was found on the bathroom floor.

The NN dated 7/29/13 at 6:10 A.M. revealed the resident was found on the floor in the bathroom.

The NN dated 8/28/13 at 3:50 P.M. revealed the resident was found on the floor in the bathroom.

The Potential Bowel/Bladder Retraining Assessment dated 1/11/13 revealed a score 11, on 4/15/13 a score of 13, and on 7/15/13 a score of 12. A score of 7 to 14, indicated the resident was a candidate for toilet training (timed voiding). The plan consisted of toileting upon arising, before bedtime/retiring, and before and after meals. The resident wore incontinent briefs when up, nursing staff would ask the resident of the need to toilet when awake during the night, and nursing staff would check and change the resident when wet.

Record review on 10/17/13 at 8:11 A.M. lacked documentation of a 3-day voiding diary.

Observation on 10/16/13 at 12:35 P.M. revealed direct care staff Q and R assisted the resident to the bathroom for toileting via gait belt after the lunch meal.

Interview on 10/17/13 at 10:53 A.M. with direct care staff Q stated the resident required assistance with toileting.

Interview on 10/17/13 at 11:23 A.M. with licensed nursing staff H stated a 72 hour bowel and bladder voiding program should be initiated on

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F 315	Continued From page 29 admission. Interview on 10/17/13 at 2:37 P.M. with administrative nursing staff D stated a Bowel and Bladder Assessment/72 Hours Voiding Pattern was initiated upon admission. The facility failed to provide a Policy and Procedure for a 72 Hour Voiding Pattern. The facility failed to establish a voiding pattern for this cognitively impaired resident. - Review of resident #33's Physician Order Sheet (POS) dated 10/2/13 identified the resident had a diagnosis of benign prostatic hyperplasia (enlargement of the prostate). The resident's admission Minimum Data Set (MDS) 3.0 dated 7/4/13 identified the resident scored 6 (severely impaired cognition) on the Brief Interview for Mental Status and was always continent of urine. Review of the resident's clinical record lacked evidence to support the facility completed the Care Area Assessment for the comprehensive assessment with an assessment reference date of 7/4/13. The resident's quarterly Minimum Data Set (MDS) dated 8/20/13 identified the resident scored 5 (severely impaired cognition), and had physical and verbal behaviors 1 to 3 days of the 7 days look back period. The MDS identified the resident independent with bed mobility, required staff supervision with transfers, walking in the room, and locomotion on/off the unit, and limited staff assistance with dressing, toilet use and	F 315		

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personal hygiene. The MDS identified the resident was occasionally incontinent of urine, and was not on a current toileting program.

The resident's care plan reviewed 8/21/13 included upon admission to the facility the resident was continent of urine. An entry dated 7/11/13 included staff observed the resident was incontinent of urine. An entry dated 9/16/13 included the resident ambulated to the toilet, was unable to hold his/her urine, and slipped on urine on the floor. The resident's care plan did not include a toileting schedule/program.

A Potential Bowel and Bladder Retraining form dated and signed 8/2/13 included the resident scored 19 (there was no legend to indicate what the score represented). The form included the resident always voided correctly and was continent, the resident independently ambulated or transferred self to the bathroom/toilet/commode, and managed clothing and hygiene independently. The form included the resident was mentally aware of his/her toileting needs. The evaluation included the resident toileted self.

The resident's clinical record lacked evidence to support the facility reassessed the resident's urinary status or performed a 3 day voiding diary after the resident's urinary status changed from always continent to occasionally incontinent of urine.

On 10/16/13 at 9:30 A.M. direct care staff P stated the resident was continent of urine during the day and was incontinent of urine at night. Direct care staff P stated the resident toileted himself/herself during the day and was not on a toileting program.

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F 315	Continued From page 31 On 10/16/13 the resident laid in bed on his/her back, the resident was very pleasant and confused. On 10/16/13 at approximately 2:55 P.M. direct care staff R performed an incontinent check on the resident and stated the resident was not incontinent. Direct care staff R stated the resident was incontinent during the night but was continent during the day. Direct care staff R stated the resident was not on a toileting program and the resident toileted himself/herself. On 10/17/13 at approximately 12:30 P.M. direct care staff Q performed an incontinence check and the resident was not incontinent. On 10/17/13 at approximately 2:15 P.M. administrative nursing staff D stated the resident was occasionally incontinent of urine. Administrative nursing staff D stated the facility completed bladder assessments and 3 day voiding patterns upon admission but the facility had not developed a system to perform bladder assessments and/or 3 day voiding diaries after admission. On 10/17/13 at approximately 2:30 P.M. administrative nursing staff E confirmed the facility did not complete a bladder assessment or perform a 3 day voiding diary after the resident's incontinence status changed. On 10/17/13 at approximately 2:54 P.M. licensed nurse H stated the resident was incontinent of urine at times, staff checked the resident during the day to see if the resident was incontinent but the resident was not on a toileting program.	F 315		

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F 315	Continued From page 32 The facility did not provide policy and procedures on urinary incontinence. The facility failed to reassess this severely cognitively impaired resident's urinary pattern after the resident experienced a decline in his/her voiding pattern.	F 315		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This Requirement is not met as evidenced by: The facility had a census of 37 residents. The sample included 22 residents. Based upon record review, observation, and interviews the facility failed to maintain an environment free of accident hazards and failed to implement timely and effective interventions to prevent falls for 3 (#5, #29, #21) of 3 residents sampled for falls. Resident #29's falls resulted in fractures and a laceration. Findings included: - Review of resident #29's significant change Minimum Data Set (MDS) 3.0 dated 9/7/13 identified the resident scored 1 (severely impaired cognition) on the Brief Interview for Mental Status, displayed physical behaviors and wandered on a daily basis during the 7 day look back period. He/she had verbal behaviors 1 to 3 days of the 7 day look back and other behaviors	F 323		

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not directed toward others 4 to 6 days of the 7 day look back. The MDS recorded the resident required extensive staff assistance with bed mobility, transfers, walking in the room/corridor, locomotion off the unit, dressing, eating, toilet use, and personal hygiene, and limited staff assistance with locomotion on the unit. The MDS coded the resident was not steady and only able to stabilize with staff assistance when moving from seated to standing position, walking, turning around while walking, on/off the toilet, and surface-to surface transfer. The MDS identified the resident was always incontinent of urine and had 1 non injury fall, 2 or more non- major injury fall and 1 fall with major injury since the prior assessment.

The resident's care plan initiated on 1/6/12 documented the resident at a high risk for injury falls and had a history of a right wrist fracture. The care plan listed the fall interventions: call light available at bed and chair, ensure the resident wore non-slip footwear for all transfers and ambulation, 2 to 1 assist with gait belt and caution for all transfers, help in the avoidance of clutter in areas traveled to reduce fall risk, consider providing slightly tinted inexpensive sunglasses to see if they will reduce glare from the walls, and staff toileted the resident every 2 hours and as needed. The facility did not consistently date when they initiated new interventions.

A nurse's note (NN) dated 4/15/13 and timed 9:40 A.M. documented staff found the resident on the floor sitting on the scales. The care plan lacked evidence of additional fall interventions.

A NN dated 6/9/13 and timed 10:20 A.M. documented the resident stood up from the

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couch, fell on his/her right side, and hit his/her hip, shoulder, wrist and head on the floor. The note documented the resident complained of wrist pain, the resident's right wrist was swollen, and the facility received a physician's order for an x-ray. The care plan lacked evidence of additional fall interventions.

A radiology report dated dated 6/9/13 included the resident's right wrist was painful after the trauma and the impression was the resident had a comminuted distal radial ulnar fracture with apex ventral angulation of the radius (broken wrist).

A NN dated 6/10/13 and timed 10:45 A.M. documented the resident tried to sit on the end of the extended footrest of the recliner and fell onto his/her bottom. The care plan lacked evidence of additional fall interventions.

A NN dated 6/13/13 and timed 1:10 A.M. documented the resident had a bruise on the right side of his/her forehead that measured 5 centimeters (cm) by 6 cm.

A NN dated 6/13/13 and timed 6 A.M. to 6 P.M. documented the resident returned from a physician's appointment with a forearm/wrist cast on his/her right arm. The note included at approximately 5:00 P.M. the resident leaned up against the fireplace and slid to the floor. The care plan lacked evidence of additional fall interventions.

A NN dated 6/30/13 and timed 2:00 P.M. documented staff found the resident on the floor behind the recliner in the sitting area. The care plan lacked evidence of additional fall interventions.

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F 323	Continued From page 35 A NN dated 7/4/13 and timed 3:32 P.M. documented staff observed the resident seated on the floor by the fireplace. The care plan lacked evidence of additional fall interventions. A NN dated 7/5/13 and timed 2:15 P.M. documented staff found the resident on the floor at 11:30 A.M. and 12:30 P.M. with no injuries noted. The care plan lacked evidence of additional fall interventions. A NN dated 7/12/13 and timed 9:13 A.M. documented the resident fell at 8:50 A.M. The NN included the resident stumbled and grabbed the chair to catch his/her fall but instead the resident hit his/her head on the wall and slid on his/her buttock to the floor. The care plan lacked evidence of additional fall interventions. A NN dated 7/13/13 timed 10:30 A.M. documented the resident ambulated in the hall, when staff called to him/her, the resident lost his/her balance and staff assisted the resident to the floor. The care plan lacked evidence of additional fall interventions. A NN dated 7/27/13 and timed 2:45 P.M. documented staff found the resident on the floor in the theater room, the resident apparently fell, and had a 2 cm by 1 cm open area on his/her left brow bone with a moderate amount of bleeding. The note included staff transferred the resident to urgent care and the urgent care center glued the resident's left brow. The care plan lacked evidence of additional fall interventions. A NN dated 7/30/13 and timed 11:55 A.M. documented the resident sat on the floor next to the recliner. The care plan lacked evidence of	F 323		

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F 323	Continued From page 36 additional fall interventions. A NN dated 8/3/13 and timed 5:15 P.M. documented the resident lost his/her balance and sat on the carpeted floor. The care plan lacked evidence of additional fall interventions. A NN dated 8/8/13 and timed 6:45 A.M. documented staff found the resident on the floor in a sitting position. The care plan lacked evidence of additional fall interventions. A NN dated 8/10/13 and timed 12:00 P.M. documented staff observed the resident's lower back with a bruise that measured 8 cm by 2 cm, a purple colored bruise on the resident's right ischium that measured 3 cm in diameter, and the resident complained of back pain. A NN dated 8/14/13 and timed 2:55 P.M. documented staff observed the resident on the floor beside the love seat. The care plan lacked evidence of additional fall interventions. A NN dated 8/15/13 and timed 4:15 P.M. documented staff found the resident on the floor lying on his/her right side with a peer's walker on top of him/her. The note included the resident had a scratch to his/her forehead with a brown spot. A NN dated 8/17/13 and timed 3:10 A.M. documented the resident with 1 on 1 attention related to his/her unsteady gait. A NN dated 8/18/13 and timed 10:10 A.M. documented staff placed the resident in the recliner, about 20 minutes later the resident got up from the recliner and attempted to walk to another resident, the resident was unsteady on	F 323		

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his/her feet, started to loose his/her balance and resulted in the resident sitting down on the floor. The care plan lacked evidence of additional fall interventions.

A NN dated 8/18/13 and timed 4:00 P.M. documented the resident had multiple non injury falls. The note included at 11:45 A.M. while in the dining room at the table the resident got himself/herself out of the wheelchair, attempted to grab another nearby resident's walker and fell onto the floor. At 2:15 P.M. the resident sat in the wheelchair in front of the nurse's station, again stood up and proceeded to roll off the seat to the carpet just as staff reached him/her. The note included the facility placed a personal alarm on the resident and kept the resident close to the staff.

A Radiology Report dated 8/21/13 documented the resident had a history of posterior (back) left rib pain, and had recent falls. The report included the impression was a nondisplaced inferior lateral left eighth rib fracture (broken rib bone).

The care plan listed an intervention with no date, that stated prior to the left rib fracture identified on 8/26/13 (but completed on 8/21/13) documented the resident was in a wheel chair with a personal alarm on and a pommel cushion (designed to stabilize seating position and support hip abduction).

The care plan documented on 9/12/13 the staff placed the resident on Vitamin D (supplement) daily and discontinued the Melatonin (used for difficulty sleeping) due to falls and sleepiness

A NN dated 9/13/13 and timed 4:45 P.M. documented the resident was having difficulty

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sitting up, staff placed the resident in a recliner in a reclined position with a personal body alarm, and then staff found the resident on the floor in front of the recliner in a fetal position.

A NN dated 9/13/13 Intervention for the above fall and timed 5:05 P.M. documented the facility placed the resident's mattress on the floor with fall mats beside it.

The care plan documented on 9/25/13 the facility discontinued the resident's Zyprexa (an antipsychotic).

On 10/15/13 at 1:46 P.M. the resident laid in bed on his/her left side. Observation revealed the resident in a low bed, a fall mat on the right side of the resident's bed and a personal alarm in place.

The care plan documented on 10/16/13 staff placed the resident in a low bed in the lowest position and no side rails used.

On 10/16/13 at 8:00 A.M. 8:55 A.M., 9:05 A.M., and 9:15 A.M. the resident sat in the recliner in the lobby area of the facility, the foot of the recliner elevated and the resident appeared asleep.

On 10/16/13 at 12:15 P.M. and 12:30 P.M. the resident sat in his/her wheelchair in the television area of the facility. Observation revealed the resident leaned to the right and a personal alarm in place.

On 10/16/13 at approximately 12:55 P.M. direct care staff P and V transferred the resident from the wheelchair to the bed via a gait belt. Observation revealed the resident was totally

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dependent upon staff for the transfer. Observation revealed staff lowered the resident's bed to the floor. During interview with direct care staff P at that time the staff stated the resident had a history of falls, and only one fall mat was placed beside the resident's bed.

On 10/17/13 at 7:00 A.M. the resident was in a low bed, and a mat was beside the right side of the resident's bed.

On 10/17/13 at 1:50 P.M. administrative nursing staff D stated the resident fell more this summer than in the past. Administrative nursing staff D stated fall interventions included staff ensured the resident wore non-skid socks and shoes, staff engaged the resident in conversation/activities, monitored the resident frequently, and 75 percent of the time the resident was in direct observation of the staff. Administrative nursing staff D stated staff provided the resident with finger foods, encouraged this severely cognitively impaired resident to use his/her walker, the facility discontinued the resident's Zyprexa on 3/25/13, and started the resident on Vitamin D. Administrative nursing staff D stated the resident had impaired vision and the facility had not pursued the sunglasses included in the resident's care plan. Administrative nursing staff D stated the facility placed the resident's mattress on the floor and placed mats on both sides of the resident's bed in September of 2013 and later that month the facility placed the resident in a low bed that lowered to the floor. Administrative nursing staff D stated the facility placed the resident in a wheelchair with a pommel cushion during August of 2013. Administrative nursing staff D stated it was his/her understanding the resident's personal alarm did not activate when the resident fell on 9/13/13. Administrative

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F 323	Continued From page 40 nursing staff D stated the resident should have fall mats on both sides of his/her bed. On 10/17/13 at 3:00 P.M. licensed nurse H stated the resident had a history of falls, the resident utilized a personal alarm and a low bed with mats on both sides of the bed. He/she stated prior to the low bed the facility placed the resident's mattress on the floor. Licensed nurse H stated the facility kept the resident in line sight of staff. The facility did not provide a fall policy and procedure. The facility failed to implement timely and effective interventions for this dependent resident with severely impaired cognition with a history of falls. This resident had 22 falls in less than 6 months and sustained a rib and wrist fracture and a laceration that required a transfer to urgent care. - Review of resident #5's significant change Minimum Data Set (MDS) dated 8/6/13 identified the resident scored 0 (severely impaired cognition) on the Brief Interview for Mental Status, had other behavioral symptoms not directed toward others occurred 4 to 6 days during the 7 day look back period. The MDS coded the resident required extensive staff assistance with bed mobility, transfers, walking in the room/corridor, locomotion on/off the unit, dressing, eating, toilet use, and personal hygiene and was frequently incontinent of urine. The MDS recorded the resident was not steady, only able to stabilize with staff assistance when moving from seated to standing position, walking, turning around with walking, moving on/off toilet, and surface to surface transfer. The MDS coded the	F 323		

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resident had 1 non-injury fall since the prior assessment.

The resident's Fall Risk Assessment dated 8/6/13 identified the resident scored 19 and on 5/10/13 the resident scored 20. According to the legend a score of 10 or higher represented the resident at high risk for falls.

The resident's care plan last reviewed 8/13/13 addressed the resident was at risk for falls. The care plan included the resident needed a wheelchair for mobility, the resident's personal bed was replaced with a hi-low bed with brakes on it as the resident's bed was too high, had no brakes which created a danger. The care plan included staff ensured the resident wore well fitting non-skid soled shoes, and or gripper socks when out of bed. The care plan included 2 staff transferred the resident via a gait belt or the sit/stand lift.

A nurse's note dated 4/15/13 and timed 9:00 A.M. documented staff found the resident on the floor on his/her back beside the bed.

A nurses' note dated 5/22/13 (time unknown) documented at 5:00 A.M. staff found the resident sitting on the floor beside bed leaning on the bed and the resident's right arm was in the 1/4 rail.

A nurses's note dated 7/16/13 and timed 11:10 A.M. included a volunteer pushed the resident in his/her wheelchair, the wheelchair accidentally went off the sidewalk, there was a big dip down and the resident tipped out of the wheelchair onto the ground.

A nurse's note dated 10/3/13 and timed 3:35 P.M. documented staff found the resident lying on the

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F 323	Continued From page 42 floor beside his/her bed. On 10/15/13 at 1:46 P.M. observation revealed the resident in bed on his/her back, the resident's bed was in the lowest position, and a mat beside the resident's bed. On 10/16/13 at 7:00 A.M. the resident sat in his/her wheelchair in the television area of the facility. On 10/16/13 at 12:45 P.M. direct care staff P and V transferred the resident from the wheelchair to the bed via a transfer belt. Observation revealed the resident totally dependent upon staff during the transfer. After staff finished performing care for the resident at approximately 12:48 P.M., staff placed the mat beside the resident's bed and observation revealed the resident's bed was not in the lowest position. During interview with direct care staff P at approximately 1:00 P.M., staff stated the resident's bed was not in the lowest position. Direct care staff P lowered the resident's bed to the lowest position and observation revealed the resident's bed was approximately 5 inches from the ground. On 10/17/13 at approximately 7:05 A.M. the resident laid in bed. Observation revealed the resident's bed was not in the lowest position and the fall mat approximately 6 inches from the resident's bed and positioned horizontally. On 10/17/13 at approximately 2:15 P.M. administrative nursing staff D stated the resident had a history of falls. Administrative nursing staff D stated the facility had placed a fall mat beside the resident's bed, performed a 3 day voiding diary upon admission, assessed the resident's pain using a pain scale for dementia (loss of brain	F 323		

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function), adjusted the resident's Neurontin (medication that can be used to treat seizures and pain), and checked the resident for toileting.

On 10/17/13 at 2:45 P.M. licensed nurse H stated staff placed a fall mat beside the resident's bed, the resident utilized a high-low bed and the resident's bed should be in the lowest position at all times.

The facility did not provide a fall policy and procedure.

The facility failed to ensure the resident's fall mat was properly placed and the resident's bed in lowest position as planned for this resident with severely impaired cognition and a history of falls.

- The significant change Minimum Data Set 3.0 dated 7/23/13 for resident #21 revealed a Brief Interview for Mental Status score of 2 (severe cognitive impairment). The resident required extensive assistance of two plus (2+) persons for bed mobility, transfer, and toilet use, and required extensive assistance of one person for locomotion on/off the unit, dressing, personal hygiene, and bathing. The resident was not steady and stabilized with staff assistance with moving from a seated to standing position, walking, turning around while walking, moving on/off the toilet, and surface to surface transfers. She/he had range of motion limitations to the upper/lower extremities on one side, and used a walker and wheelchair (w/c) for mobility. The resident was frequently incontinent of urine and was always continent of bowel. She/he had two or more non-injury falls since admission/reentry/prior assessment.

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F 323	Continued From page 44 The Care Area Assessment (CAA) dated 7/25/13 for falls revealed the resident had all her/his toes and part of her/his right foot removed as a result of a job accident in the 1960's. Her/his right foot, left hemiparesis (muscular weakness of one half of the body), and aphasia (condition in which language function is disordered or absent) placed the resident at risk for falls. The resident wore a special orthotic shoe on her/his right foot and an athletic shoe on the left foot. A pommel cushion (designed to stabilize seating position and support hip abduction) was used to discourage standing without assistance, and as a reminder to wait for assistance for transfer. The resident had a floor mat beside the left side of the bed, and quarter rails in an up position on either side of the bed to assist with repositioning in bed. The updated care plan dated 8/30/13 for at risk for falls revealed the resident required assistance of 2 to (:) 1 with a gait belt for transfers and toileting, required a gait belt with all ambulation, nursing staff would monitor for changes in the resident's condition which warranted increased supervision/assistance and would notify the physician of significant concerns, the resident used a w/c for long distance mobility, side rails in the up position for bed mobility while in bed, nursing staff would remind the resident to ask and wait for assist with transfers and ambulation, toilet upon rising and before/after meals, and provided perineal care when incontinent. Record review on 10/16/13 at 4:00 P.M. of handwritten fall events and interventions provided by administrative nursing staff A revealed: The Nursing Notes (NN) dated 5/10/13 at 8:00 A.M. revealed at 7:50 A.M. the resident tried to	F 323		

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transfer self to the toilet in her/his room without help, lost her/his balance and fell to the floor. The handwritten record lacked addition fall interventions and a fall investigation.

The NN dated 5/12/13 at 6:50 P.M. revealed the resident was assisted to the toilet by nursing staff after the evening meal and after checking on the resident left the resident on the toilet and when nursing staff returned they found the resident on the floor. The handwritten record revealed the resident had a fall while self-transferring to the toilet, and lacked additional fall interventions.

The NN dated 5/15/13 at 4:30 P.M. revealed staff found the resident on the floor in doorway of her/his bathroom. The handwritten record revealed the resident had a non-injury fall while self-transferring and lacked additional fall interventions.

The NN dated 5/25/13 at 11:30 A.M. revealed staff found the resident on the bathroom floor. The handwritten record revealed the resident had a non-injury fall while transferring self from the toilet and lacked additional fall interventions.

The NN dated 7/6/13 at 4:00 P.M. revealed staff found the resident in front of the nurses' station after staff placed the resident in a recliner chair. The handwritten record revealed the resident had a non-injury fall while transferring self from a recliner chair to a w/c and lacked additional fall intervention.

The NN dated 7/9/13 at 3:30 P.M. revealed staff found the resident on the floor in her/his room. The handwritten record revealed the resident had a non-injury fall and lacked additional fall intervention

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F 323	Continued From page 46 The NN dated 7/29/13 at 6:10 A.M. revealed staff found the resident on the floor in the bathroom. The handwritten record revealed the resident sustained superficial bruising to the left upper arm and shoulder and a small abrasion with an intervention for staff to encourage (this severely cognitively impaired) resident to use the call light for assistance for toileting. The NN dated 8/28/13 at 3:50 P.M. revealed staff found the resident on the floor in the bathroom. The handwritten record revealed the resident had a non-injury fall and lacked additional fall intervention. The NN dated 9/11/13 at 3:07 P.M. revealed staff found the resident on the floor. The handwritten record revealed the resident had a non-injury fall and lacked additional fall interventions. Record review on 10/16/13 at 4:00 P.M. of handwritten fall events and interventions provided by administrative nursing staff A revealed the resident had a non-injury fall on 9/16/13 and staff encouraged the resident to wear appropriate footwear when ambulating. The NN dated 9/29/13 at 10:25 P.M. revealed staff found the resident sitting on the floor in front of her/his w/c. The handwritten record revealed the resident had a non-injury fall and had removed the PBA and the intervention included moving the PBA out of the resident's reach and applied side rails for bed mobility. The Fall Risk Assessment dated 1/11/13 revealed a total score of 15; on 4/15/13 a total score of 14; and on 7/15/13 a total score of 6 where a total score above 10 represented a high	F 323		

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F 323	Continued From page 47 risk for falls. Observation on 10/16/13 at 7:34 A.M. revealed the resident sat in a w/c, self-propelled in the hallway, and wore a PBA. Observation on 10/16/13 at 9:44 A.M. revealed the resident laid in bed sleeping, wore a PBA, the side rails were in up position with the bed in low position. Interview on 10/17/13 at 10:53 A.M. with direct care staff Q stated nursing staff educated (this severely cognitively impaired) resident regarding the consequences of transferring her/himself without assistance. The resident required visual monitoring, sat in a recliner chair in the common area, wore a PBA while in bed/wheelchair, the bed was placed in the low position, and the resident could not be left alone in the bathroom during toileting. Interview on 10/17/13 at 11:23 A.M. with licensed nursing staff H stated the resident wore a PBA while in the bed and wheelchair. The resident's family did not want a bed alarm used. The resident was not steady enough to ambulate by her/himself due to having only one entire foot. Nursing staff should initiate an incident report with a fall. Interview on 10/17/13 at 2:37 P.M. with administrative nursing staff D stated nursing staff initiated incident reports. The facility failed to provide a policy and procedure for falls. The facility failed to have effective interventions in place for the prevention of falls for this cognitively	F 323		

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F 323	Continued From page 48 impaired resident with a history of numerous falls. - Observations during the initial tour on 10/14/13 from 9:30 A.M. to 10:30 A.M., revealed the facility lacked non-skid strips in 2 of 2 common bathing rooms. Interview on 10/17/13 at 9:30 A.M. direct care staff P stated staff should put towels down on the floor when showering a resident to prevent slipping. Interview on 10/17/13 at 10:00 A.M. licensed nursing staff H stated staff should put towels down on the floor when showering a resident to prevent slipping. Interview on 10/17/13 at 1:30 P.M. administrative staff D stated staff should put towels down on the floor when showering a resident to prevent slipping. The facility failed to provide a policy on preventing accidents. The facility failed to provide an environment free of accident hazards. - Observations during the initial tour on 10/14/13 from 9:30 A.M. to 10:30 A.M., Hall B's unlocked bathroom had a bottle of disinfectant spray in an unlocked cabinet. This bottle noted a caution to keep out of the reach of children and harmful if swallowed. Interview on 10/17/13 at 9:30 A.M. direct care staff P stated staff should keep the cabinet locked at all times, and the key should not be in the lock.	F 323		

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F 323	Continued From page 49 Interview on 10/17/13 at 10:00 A.M. licensed nursing staff H stated staff were to keep the cabinet locked at all times, and the key should not be in the lock. Interview on 10/17/13 at 1:30 P.M. administrative staff D stated staff were to keep the cabinet locked at all times, and the key should not be in the lock. The facility failed to provide a policy on the storage of chemicals. The facility failed to provide an environment free of accident hazards.	F 323		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This Requirement is not met as evidenced by: The facility had a census of 37 residents. The sample included 22 residents. Based upon record review, observations, and interviews the facility failed to ensure that residents received staff assistance with meals consistently and failed to offer an alternative or monitor nutritional intake for 2 (#19, #21) of 2 residents reviewed for nutrition.	F 325		

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F 325	Continued From page 50 Findings included: - Review of resident #19's significant change Minimum Data Set (MDS) 3.0 dated 9/16/13 identified the resident scored 0 (severely impaired cognition) on the Brief Interview for Mental Status, and had behaviors 4 to 6 days of the 7 day look back period. The MDS identified the resident required extensive staff assistance with bed mobility and locomotion on/off unit, and was totally dependent upon staff for transfers, walking in the room, dressing, eating, toilet use, and personal hygiene, The MDS coded the resident weighed 166 pounds, and had not experienced a weight loss. The resident's clinical record did not support the facility completed the Care Area Assessments as required after completing the significant change assessment (a comprehensive assessment). The resident's care plan with a review date of 9/17/13 included the resident received a regular diet and staff documented the percentage of meals consumed. An entry dated 8/30/13 included the resident received Ensure pudding (nutritional supplement with extra protein and calories) at lunch and supper, super cereal (ingredients added to cereal to increase protein and calories) at breakfast and staff assisted the resident with meals as needed. Review of the resident's weight log revealed the following weights: 2/1/13: 174 pounds (#) 3/3/13: 170# 4/1/13: 159# 5/1/13: 165# 6/2/13: 165#	F 325		

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F 325	Continued From page 51 7/1/13: 168# 8/2/13: 160# (weight loss of 14#'s or 8.04 percent of the resident's body weight in 6 months). 9/1/13: 166# 10/6/13:164# The resident's laboratory report dated 10/9/13 recorded the resident's low serum albumin (indicator of protein storage) level at 2.6 grams/deciliter (gm/dl), normal reference level at 3.5-5.2 gm/dl. The report recorded the resident's low total protein as 5.3 gm/dl, normal reference range of 6.6-8.7 gm/dl. A registered dietician's (RD) note dated 4/23/13 documented the resident currently weighed 159 pounds, in March of 2013 the resident weighed 170 pounds, and in December of 2012 the resident weighed 164 pounds. The note included the resident's weight was down 10 pounds in 1 month, down 5 pounds in 4 months and the resident's ideal body weight was 190 pounds. The note included the dietician recommended the resident to receive super cereal at breakfast on a daily basis. An undated registered dietician's annual assessment note documented the resident weighed 164 pounds, the resident's weight was stable, the resident's laboratory values were within normal limits, and staff offered the resident snacks between meals. A registered dietician's note dated 8/28/13 documented the resident weighed 163 pounds, and the resident had a gradual weight loss. The note included the resident's weight decreased 4.5 percent (%) in 1 month, 3% in 3 months, 7.8% in 6 months, and the RD recommended 2 cal (60	F 325		

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F 325	Continued From page 52 cubic centimeters twice a day to try and stabilize the resident's weight. A nurse's note dated 9/5/13 timed 9:15 A.M. included the facility received a physician's order to start the resident on 2 Cal (a high-calorie formula designed to meet increased protein and calorie needs) 60 cubic centimeters (cc) with medication pass twice a day secondary to weight loss. Review of the resident's 10/1/13 to 10/16/13 medication administration record revealed the resident usually consumed 100 percent of the 2 cal. Review of the resident's October 2013 meal intake log for 10/1/13 to 10/16/13 revealed the following: Breakfast: the resident did not consume the breakfast meal 3 times, consumed 5-25% 6 times and refused the meal once Lunch: the resident did not consume the meal twice, and consumed 25% or less 5 times Supper: the resident did not consume the meal 4 times, and consumed 50% or less of the meal 3 times Ensure pudding at the lunch meal: the resident consumed 25% or less 7 times Ensure pudding at supper: the resident consumed 25% or less twice Review of the resident's between meal nourishment/snack record from October 1 to the 16th, 2013 revealed the facility did not consistently document the amount of the nourishment/snack the resident consumed. For example the facility only recorded 4 times the resident received or was offered an after breakfast/before lunch snack, recorded 3 times	F 325		

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the resident received or was offered an after lunch/before dinner snack and there was no documentation recorded for the after dinner/before bedtime snack/nourishment.

The resident's clinical record lacked evidence to support the facility consistently offered the resident an alternative if the resident did not consume the meals.

On 10/15/13 at 7:35 A.M., 7:38 A.M., 7:40 A.M., 7:45 A.M. and at 7:49 A.M. the resident sat at the dining room table and the resident's breakfast meal sat in front of him/her. Observation revealed the resident did not consume any of the meal and no staff assisted or cued the resident to eat. At 7:49 A.M. staff assisted the resident with the breakfast meal. At 8:01 A.M. the resident ate 75% of the breakfast meal.

On 10/16/13 at 7:48 A.M. the resident sat in his/her wheelchair at a dining room table and dietary staff placed the resident's breakfast meal in front of the resident. Observation revealed the meal included a cinnamon roll, super cereal, sausage, juice, coffee and milk. Observation revealed the resident picked up the cinnamon roll and began to eat it. At 7:53 A.M., 7:57 A.M., and 7:59 A.M. the resident had consumed 25% of the cinnamon roll and the resident just sat at the dining room table and did not attempt to eat the meal. Observation revealed staff in the area but did not cue and/or assist the resident with the meal. At 8:03 A.M. the resident wheeled slightly away from the dining room table. Observation revealed no staff assisted or cued the resident to eat. At 8:04 A.M. direct care staff Q approached the resident, called the resident by name and encouraged the resident to eat. Direct care staff Q wheeled the resident back to the dining room

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table, locked the brakes on the resident's wheelchair, handed the resident the glass of juice and then walked away. Observation revealed the resident drank the juice. At 8:06 A.M. direct care staff Q assisted the resident with the sausage and the resident consumed the sausage. Observation revealed direct staff Q alternated between tables and assisted residents with the breakfast meal. At 8:20 A.M. the resident consumed the super cereal, sausage, juice, 1/2 of the milk and 95% of the cinnamon roll. At 8:25 A.M. the resident consumed 100% of the meal and fluids.

On 10/17/13 at 9:20 A.M. and 9:25 A.M. the resident sat in his/her wheelchair and the resident's breakfast sat in front of the resident. The meal included sausage and super cereal. Observation revealed the resident did not consume any of the meal. Further observation revealed staff in the area and did not cue or assist the resident with the breakfast meal.

On 10/17/13 at approximately 12:40 P.M. dietary staff EE stated if the resident consumed 25% or less of meals, staff offered the resident something else to drink.

On 10/17/13 at approximately 3:00 P.M. licensed nurse H stated the resident's weight fluctuated up and down, and the resident needed staff encouragement and coaching during meals. Licensed nurse H stated staff offered the resident an alternative if the resident did not eat what was on his/her plate. Licensed nurse H stated the resident received snacks and a protein shake in between meals.

The facility policy and procedure included upon accurately identifying a weight change of concern

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F 325	Continued From page 55 (or significant/severe), the facility initiated Phase 1. The program's main focus was weight loss. In Phase 1 staff reviewed the resident's meal/snack intake, reviewed most recent laboratory values and considered the need for fortified foods...if weight changes continued the facility considered the need for nutritional supplement(s). The facility failed to timely assist this severely cognitively impairment, totally dependent resident for eating, failed to consistently document the percentage of snacks/supplement the resident consumed, and failed to consistently offer this resident an alternative when he/she did not consume the food offered. - The significant change Minimum Data Set (MDS) 3.0 dated 7/23/13 for resident #21 revealed a Brief Interview for Mental Status score of 2 (severe cognitive impairment). The resident required extensive assistance of two plus (2+) persons for bed mobility, transfer, and toilet use, and required extensive assistance of one person for locomotion on/off the unit, dressing, personal hygiene, and bathing, and supervision with set up help only with eating. The resident was 64 inches tall and weighed 136 pounds (#), was on a physician weight loss regimen, had no weight gain, and received a mechanically altered diet. The Nutritional Care Area Assessment dated 7/25/13 revealed the resident fed her/himself a regular blended diet with honey thick liquids. She/he ate well at meals and took fluids at and between meals. The care plan dated 1/10/13 for at risk for	F 325		

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significant weight loss revealed the resident used a plate guard to help load food onto her/his silverware, received dysphagia (difficulty in swallowing) pureed with honey thick liquids as ordered, nursing staff would give the resident time to feed her/himself, nursing staff would weigh the resident weekly and notify the physician of any weight change of 3# or more in one week, monitored and documented the percentage of food eaten, and had left side drooling from her/his mouth and needed a clothing protector.

The Nutrition Assessment dated 1/11/13 revealed the resident weighed 142.8 pounds (#), her/his Estimated Nutrition Needs required 1947 kilocalories/day, protein 72 grams (gm)/day, and fluids of 1950 milliliters (ml)/day. Recommendations included providing well balanced meals prescribed by the physician and 2 cal (a nutritional supplement) twice a day (BID) at medication pass to increase protein intake.

The Nursing Weight and Nutrition Note to Provider dated 9/2/13 at 5:45 P.M. revealed the resident had a weight loss of 5.9 percent (%) in six months for March 2013, 5.71% for July 2013 at 3 months, and 0.3% for August 2013. The resident ate 75 to 100% of most meals. The resident had a history of wound challenges and was in a healthy weight range per Body Mass Index (BMI), requested a recheck of labs to check the resident's risk for malnutrition/possible existing malnutrition. Interventions requested from the physician consisted of a recheck of the resident's prealbumin with a diagnosis of unintended weight loss and standing orders for chemistry panel and complete blood count annually.

The resident weights were: 5/1/13-137.9#,

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F 325	Continued From page 57 6/6/13-140.8#, 7/1/13-136.3#, 8/12/13 -133.2#, 9/8/13 - 134#, and 10/2/13 - 128.1#. The Prealbumin dated 9/9/13 revealed a result of 16 grams/deciliter (gm/dl) (low) with a normal range of 20-40 gm/dl. The signed Telephone Order dated 9/16/13 revealed orders for Ensure Shake daily. The Medication Administration Record for September 2013 and October 2013 revealed the resident received 2 cal 30 ml BID and consumed 100%. The Resident Between-Meal Nourishment/Snack record for September 2013 revealed the resident received a shake after lunch/before dinner and consumed 100% for 7 of the 15 days documented. The Resident Between-Meal Nourishment/Snack record daily for October 1 through 17, 2013 revealed the resident received a shake after lunch/before dinner and consumed 100% for 2 of 17 days documented. Observation on 10/16/13 at 7:30 A.M. revealed the resident received a pureed breakfast and ate 75% by her/his self. Observation on 10/16/13 at 7:40 A.M. revealed direct care staff T provided Ensure Plus to the resident and she/he consumed 100%. Interview on 10/17/13 at 10:53 A.M. with direct care staff Q stated she/he was not sure if the resident received supplements. Interview on 10/17/13 at 11:23 A.M. with licensed	F 325		

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F 325	Continued From page 58 nursing staff H stated the resident received a supplement and ate meals fairly well especially if there was no one at her/his table. Interview on 10/17/13 at 12:14 P.M. with dietary staff DD stated the resident received Ensure daily for weight loss. The undated Policy and Procedure for Weight Prevention Program lacked documentation for documentation of supplements with or between meals. The facility failed to document the nourishment shake for this cognitively impaired resident with weight loss.	F 325		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329		

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This Requirement is not met as evidenced by:
The facility reported a census of 37 residents. The sample included 5 residents. Based on observation, record review, and interview, the facility failed to provide blood pressure (BP) parameters, and labs for medication monitoring for 3 (#12, #5, and #25) residents sampled for unnecessary medications.

Findings included:

- The signed Physician's Order Sheet (POS) dated 10/9/13 for resident #12 revealed diagnoses of diabetes (when the body cannot use glucose, there was not enough insulin made or the body cannot respond to the insulin), hypothyroidism (condition characterized by decreased activity of the thyroid gland), and hypertension (elevated blood pressure-HTN).

The Annual Minimum Data Set 3.0 dated 8/22/13 revealed a Brief Interview for Mental Status score of 3 (severe cognitive impairment).

The updated care plan dated 10/9/13 for fluctuating/unstable blood pressures, complications of diabetes, and hypothyroidism revealed nursing staff would provide Synthroid as ordered, would obtain thyroid stimulating hormone (TSH) as ordered and notify the physician of abnormal results. Synthroid was a black box warning medication (BBW). The nursing staff would notify the physician if the resident's systolic BP was greater than (>) 180 or less than (<) 80, and if the diastolic BP was >110

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or <50. Nursing staff would obtain a blood pressure monthly and as needed (PRN), notify the physician of change in level of alertness, one-sided weakness/facial drooping, change in clarity of speech, headaches, and dizziness. Nursing staff would obtain an accucheck as ordered weekly and would call the physician if accuchecks were over 400 or under 50, or if the resident showed symptoms of hypo or hyperglycemia (low/high sugar levels in the blood).

The signed physician order sheet (POS) dated 10/9/13 revealed orders for weekly BP and pulse (P) checks on Sunday and lacked parameters for BP and P.

The signed POS dated 10/9/13 revealed orders for Losartan 100 milligram (mg) by mouth (PO) daily, Norvasc 10 mg PO daily, and Lisinopril 10 mg PO daily for HTN. The orders lacked documentation for BP parameters.

The Medication Administration Record (MAR) for July 2013, August 2013, September 2013, and October 2013 were within normal limits per care plan parameters. The MARs lacked documentation of parameters for BP.

The signed POS dated 10/9/13 revealed orders for Synthroid 100 micrograms (mcg) PO daily for hypothyroidism.

The lab dated 8/8/13 for thyroid stimulating hormone (TSH) revealed a low result. Written on the faxed lab results, the physician ordered nursing staff to decrease Synthroid to 100 mcg daily and recheck the TSH in 6 weeks.

Record review on 10/16/13 at 4:03 P.M. lacked

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F 329	Continued From page 61 evidence the TSH was drawn in 6 weeks as ordered. Observation on 10/16/13 at 3:00 P.M. revealed the resident self-propelled her/his self around the common area and nursing station. Interview on 10/17/13 at 11:23 A.M. with licensed nursing staff H stated nursing staff would fax the physician for BP parameters and document them on the MAR. The facility currently had a staff member who kept track of resident labs. New orders for labs were given to her/him and she/he informed the lab of new orders. Interview on 10/17/13 at 1:59 P.M. with direct care staff V stated if BP parameters were not written on the MAR she/he would notify the charge nurse of any BPs of 140 on the top and 75 to 80 for the bottom number of the BP. She/he also indicated she/he wrote down the BPs obtained and the charge nurse would review the BPs for any abnormalities. Interview on 10/17/13 at 2:37 P.M. with administrative nursing staff D stated the physician provided BP parameters and nursing staff monitored the BPs and notified the physician of abnormalities. Nursing staff put the orders on the calendar and the pharmacy recommendations were sent to the physician, who returned her/his reply back to the pharmacy consultant who faxed the response to the facility. The undated policy and procedure titled Observation for Adverse Reactions and efficacy of medications revealed residents who received BP medications had BPs taken weekly. The physician would be informed of any BP reading significant to the individual resident.	F 329		

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F 329	Continued From page 62 The facility failed to monitor for the effectiveness of the HTN and thyroid medications this cognitively impaired resident received. - Review of resident #5's Physician Order Sheet dated 10/2/13 included the resident received : 10 milligrams (mg) of Buspar (an anti-anxiety - a mental or emotional reaction characterized by apprehension, uncertainty and irrational fear) daily since 4/9/13, 150 mg of Zoloft (an antidepressant - abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness) daily since 3/18/13 for depression, 12.5 mg of Seoul (an antipsychotic) for dementia (progressive mental disorder characterized by failing memory, confusion) with behavioral disturbances since 6/10/13, 500 mg of Tylenol (used to treat pain and fever) three times a day since 2/19/11, Benazepril (used to treat high blood pressure) 10 mg daily since 9/4/13, 2.5 mg of Glybride (used to help control blood sugar) daily since 8/7/13, 40 mg of Lasix (a diuretic) daily since 1/9/13, 40 mg of Pepcid (used for gastric reflux - stomach contents back into the esophagus) daily since 5/10/12, 200 mg Neurotinin (used to treat seizures and pain) three times a day since 9/4/13, and 2000 International Units of Vitamin D (vitamin) since 12/29/11. The POS included the resident was to have a hemoglobin A1C (test to determine blood sugar control for patients with diabetes - when the body can ' t use glucose, there ' s not enough insulin made or the body can ' t respond to the insulin) performed every 3 months, a hemoglobin (Hgb) (protein in red blood cells that carries oxygen) and hematocrit (HCT) (test that measures the percentage of the volume	F 329		

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F 329	Continued From page 63 of whole blood that is made up of red blood cells) performed every 6 months. Review of the resident's clinical record revealed the resident's last Hgb and HCT was performed on 3/5/13 and the last HBG A1C was performed on 3/12/13. The resident's clinical record did not support the facility performed the Hgb, HCT and Hemoglobin A1C as physician ordered. On 10/17/13 at approximately 12:15 P.M. administrative nursing staff D confirmed the facility had not performed the laboratory reports as noted above. On 1/17/13 at approximately 2:50 P.M. licensed nurse H stated the facility performed laboratory testing to ensure the effectiveness of the resident's medication as physician ordered. The facility failed to monitor the effectiveness and/or side effects of the resident's medications. - The Physicians Order Sheet (POS) for resident #25 dated October 2013 listed diagnosis of hypertension (elevated blood pressure). The quarterly Minimum Data Set 3.0 (MDS) assessment dated 8-8-2013 documented the Brief Interview for Mental Status of 4, which indicated severe impairment of cognition. The care plan for complications related to high blood pressure dated 8-15-13 documented staff were to take the resident's blood pressure monthly and as needed. Staff were to notify the	F 329		

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F 329	Continued From page 64 resident's doctor if the resident's systolic blood pressure was over 160 Millimeters of Mercury (mmHg) or under 100 mmHg or if the resident's diastolic blood pressure was over 100 mmHg and staff to notify the doctor of concerns. The Physicians Order Sheet (POS) dated 10-2-13 documented weekly blood pressure, staff were to call the doctor if systolic was less than 100 mmHg or greater than 160 mmHg or diastolic was greater than 100 mmHg with the start date of 6-20-11. Hyzaar 100/25 milligram 1 tablet by mouth daily for hypertension was started 11-19-12. Norvasc 5 milligrams 1 tablet by mouth daily for hypertension was started 8-26-13. The Medication Administration Record (MAR) dated September 2013 revealed weekly blood pressures, staff to call the doctor if the systolic was less than 100 mmHg or greater than 160 mmHg or diastolic was greater than 100 mmHg. The scheduled BP dates of the 1st, 15th, 22nd and 29th lacked BPs. The MAR dated August 2013 revealed on the 25th the blood pressure of 189/83. The MAR dated July 2013 revealed the scheduled BP dates of the 7th, 14th, and 21st lacked BPs. The blood pressure on the 28th was 174/68. An observation dated 10-16-13 at 9:41 A.M. revealed the resident laid in bed awake watching television. On 10-17-13 at 1:24 P.M. direct care staff P stated when Certified Nursing Assistants (CNA) were asked to do vital signs, they would, but the CNAs do not do them regularly.	F 329		

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F 329	Continued From page 65 Interview dated 10-17-13 at 7:33 A.M. licensed nursing staff H acknowledged the July 2013 MARs: 7th,14th, 21st- displayed no documentation and stated the blood pressures should had been recorded on the MARs. On the 28th the staff did not notify the physician of the high BP of 174/68. The September 2013 MARS revealed 1st, 15th, 22nd and 29th displayed no documentation Licensed nursing staff H acknowledged the blood pressures should had been recorded on the MARs. The facility failed to provide the requested policy regarding blood pressure monitoring. The facility failed to monitor for the effectiveness of the medications for HTN.	F 329		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This Requirement is not met as evidenced by: The facility reported a census of 37 residents. The sample included 5 residents. Based on observation, record review, and interview, the facility's pharmacy consultant failed to identify and report the lack of blood pressure (BP) parameters, and labs for medication monitoring	F 428		

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	17E294	A. BUILDING _____ B. WING _____	10/23/2013

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F 428	Continued From page 66 for 1 (#12) resident sampled for unnecessary medications. Findings included: - The signed Physician's Order Sheet (POS) dated 10/9/13 for resident #12 revealed diagnoses of diabetes (when the body cannot use glucose, there was not enough insulin made or the body cannot respond to the insulin), hypothyroidism (condition characterized by decreased activity of the thyroid gland), and hypertension (elevated blood pressure - HTN). The Annual Minimum Data Set 3.0 dated 8/22/13 revealed a Brief Interview for Mental Status score of 3 (severe cognitive impairment). The updated care plan dated 10/9/13 for fluctuating/unstable blood pressures, complications of diabetes, and hypothyroidism revealed nursing staff would provide Synthroid (a thyroid medication) as ordered, would obtain thyroid stimulating hormone (TSH) test as ordered and notify the physician of abnormal results. Synthroid was a black box warning medication (BBW). The nursing staff would notify the physician if the resident's systolic BP was greater than (>) 180 or less than (<) 80, and if the diastolic BP was >110 or <50. Nursing staff would obtain a blood pressure monthly and as needed (PRN), change in level of alertness, one-sided weakness/facial drooping, change in clarity of speech, headaches, and dizziness. Nursing staff would obtain an accucheck (a blood sugar test) as ordered weekly and would call the physician if accuchecks were over 400 or under 50, or if the resident showed symptoms of hypo or hyperglycemia (low/high sugar levels in the blood).	F 428		

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F 428	Continued From page 67 The signed physician order sheet (POS) dated 10/9/13 revealed orders for weekly BP and pulse (P) checks on Sunday and lacked parameters for BP and P. The signed POS dated 10/9/13 revealed orders for Losartan 100 milligram (mg) by mouth (PO) daily, Norvasc 10 mg PO daily, and Lisinopril 10 mg PO daily for HTN. The orders lacked documentation for BP parameters. The Medication Administration Record (MAR) for July 2013, August 2013, September 2013, and October 2013 were within normal limits per care plan parameters. The MARs lacked documentation of parameters for BP. The signed POS dated 10/9/13 revealed orders for Synthroid 100 micrograms (mcg) PO daily for hypothyroidism. The lab dated 8/8/13 for thyroid stimulating hormone (TSH) revealed a low result. Written on the faxed lab results, the physician ordered nursing staff to decrease Synthroid to 100 mcg daily and recheck the TSH in 6 weeks. Record review on 10/16/13 at 4:03 P.M. lacked evidence the TSH was re-drawn in 6 weeks as ordered. The Medication Regimen Reviews (Pharmacist Communication Sheet) dated 7/16/13, 8/12/13, 9/2/13, and 10/1/13 revealed recommendations for an A1C (blood sugar level test). Record review on 10/16/13 at 4:17 P.M. lacked evidence of orders to obtain an A1C. The record revealed the last A1C obtained was 11/29/12 with	F 428		

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F 428	Continued From page 68 a high result. Observation on 10/16/13 at 3:00 P.M. revealed the resident self-propelled her/his self around the common area and nursing station. Interview on 10/17/13 at 11:23 A.M. with licensed nursing staff H stated nursing staff would fax the physician for BP parameters and document them on the MAR. The facility currently had a staff member who kept track of resident labs. New orders for labs were given to her/him and she/he informed the lab of new orders. The pharmacy consultant FF faxed recommendations to the physician, the physician would fax the response back to pharmacy consultant FF. The pharmacy consultant FF would then fax the response to the facility. Interview on 10/17/13 at 1:59 P.M. with direct care staff V stated if BP parameters were not written on the MAR she/he would notify the charge nurse of any BPs of 140 on the top and 75 to 80 for the bottom number of the BP. She/he also indicated she/he wrote down the BPs obtained and the charge nurse would review the BPs for any abnormalities. Interview on 10/17/13 at 2:37 P.M. with administrative nursing staff D stated the nursing staff placed new lab orders on the calendar and the pharmacy recommendations were sent to the physician, who returned her/his reply back to the pharmacy consultant who faxed the response to the facility. On 10/21/13 at 3:30 P.M. Pharmacy Consultant FF was not available for interview. The undated policy and procedure titled	F 428		

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F 428	Continued From page 69 Observation for Adverse Reactions and efficacy of medications revealed residents who received BP medications had BPs taken weekly. The physician would be informed of any BP reading significant to the individual resident. The facility Pharmacy Consultant FF failed to identify and report the lack of monitoring of medications for this cognitively impaired resident who received HTN, diabetic and thyroid medications.	F 428		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and	F 431		

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F 431	Continued From page 70 Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This Requirement is not met as evidenced by: The facility identified a census of 37 residents. Based on observation, record review, and interview, the facility failed to store all drugs in locked compartments. Findings included: - During initial tour on 10/14/13 at 9:50 A.M. direct care staff M left the medication cart unlocked and unattended. Interview on 10/14/13 at 9:55 A.M. direct care staff M stated the lock on the medication cart was broken. Interview on 10/17/13 at 11:00 A.M. licensed nursing staff D stated he/she was unaware the lock on the medication cart was broken. Interview on 10/17/13 at 11:05 A.M. administrative nursing staff B confirmed the lock on the medication cart was broken. He/She stated the staff were to keep the medication cart within visual range. The facility failed to provide a policy on medication storage. The facility failed to store all drugs in locked compartments.	F 431		
F 441	483.65 INFECTION CONTROL, PREVENT	F 441		

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F 441 SS=F	Continued From page 71 SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This Requirement is not met as evidenced by:	F 441		

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F 441	Continued From page 72 The facility had a census of 37 residents. The sample included 22 residents. Based on observation, record review and staff interview, the facility failed to provide hand washing after touching dirty dishes and failed to change gloves after providing perineal care for resident #13. Findings included: - An observation dated 10-14-13 at 12:10 P.M. revealed direct care staff O did not wash his/her hands after handling soiled/used dishes, then proceeded to pass medications. Observation on 10-16-13 at 11:02 A.M. revealed direct care staff P provided perineal care for resident #13 and without changing gloves picked up a plastic cup from the sink and filled the cup with water and poured the water in the soiled commode container then he/she placed the cup back on the sink and did not remove the plastic cup from sink before leaving the room. Interview dated 10-17-13 at 3:18 P.M. with administrator nursing staff D stated he/she would expected staff to wash their hands or use foam. His/her expectation was for staff to use a graduated cylinder to rinse out the commode container and store the graduated cylinder in the bathroom. The facility failed to a provide policy on hand washing. The facility failed to provide care in a sanitary manner.	F 441		